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## Sample Claim for FQHC/RHC Providers Core Visit with Immunizations

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1. MEDICARE	MEDICAID	CHA	AMPUS		CHAMPV	Ą	GROUP HEALTH	FE	CA OTHER	1a. INSURE	D'S I.D. NU	IMBER		(	FOR PF	OGRAM IN ITEM 1)	7	
(Medicare #)	r) [ (Spo	nsor's S	SN)	(VA File	#)	(SSN or	90000000M											
2. PATIENT'S NAME (L	ast Name,	First Name,	Middle I	nitial)	<del>d</del>	3. PAT	IENT'S BI	TH DATE	SEX	4. INSURED	'S NAME (	Last Nar	ne, First	Name,	Middle I	nitial)		
Smith, He	raile	<b>c</b>				12	105	1999 M	▼ F									
5. PATIENT'S ADDRES					· · · · ·			ATIONSHIP TO	7. INSURED'S ADDRESS (No., Street)									
12 Mt Olympia Drivo							Spoo	use Child										
12 Mt. Olympus Drive							IENT STA		CITY STATE							٦,		
								_								MOLE A MO		
<u>Durham</u> NC							Single	Married	Other	ZIP CODE			TELE	PHON	E (INCLI	JDE AREA CODE)	<b>⊢!</b>	
ZIP CODE TELEPHONE (Include Area Code)						Fmn	loyed	Full-Time -	- Part-Time	Zir CODE			1 2		) 	DDE AMEA 000E)	Č	
55555 ( 555) 555–5555							<u> </u>	Student	11, INSURED'S POLICY GROUP OR FECA NUMBER							<u>ا</u> د		
OTHER INSURED'S	NAME (Las	t Name, Firs	t Name,	Middle I	nitial)	10. IS	PATIENT:	S CONDITION	RELATED TO:	11. INSURE	D'S POLIC	Y GROL	JP OR F	ECA NU	JMBER			
						_												
. OTHER INSURED'S	POLICY OF	R GROUP N	UMBER			а. ЕМР	LOYMENT	r? (CURRENT	a. INSURED'S DATE OF BIRTH  MM   DD   YY									
						Ì		YES [	NO	· "	MM   DD   TT M F							
OTHER INSURED'S	DATE OF E	BIRTH	SEX			b. AUT	O ACCIDE	NT?	PLACE (State)	b. EMPLOY	ER'S NAME	OR SC	HOOL N	MANE				
MM   DD   YY		M	٦ .	F	1	-		YES	] NO									
G. EMPLOYER'S NAME OR SCHOOL NAME						c. OTH	ER ACCID	ENT?		c. INSURAN	CE PLAN	NAME O	R PROC	SRAM N	IAME		7	
G. Em. Coren o mine on concernme								YES [	<b>ี</b> พอ								11.1.1.1	
INCHEADOR OF ANY	IAME OF T	BOGBANA	JAME			104 0		FOR LOCAL I		d. IS THERE	ANOTHE	R HEAL	TH BEN	EFIT PI	AN?		닉;	
1. INSURANCE PLAN NAME OR PROGRAM NAME								. J 2000	<del>-</del>			-				molete item 0 a d		
READ BACK OF FORM BEFORE COMPLETIN							ING THE	FORM		13 INSTIRE		NO ITHORIZ				mplete item 9 a-d.  TURE I authorize	$\dashv$	
12. PATIENT'S OR AUT	THORIZED	PERSON'S	SIGNAT	TURE 1	uthorize the	release o	of any medi	ical or other inf	ormation necessary	payment	of medical	benefits				sician or supplier for		
to process this claim	. I also requ	est payment	of gover	rnment be	enelits eithe	r to mysel	f or to the p	party who acce	pts assignment	services	described	below.		•				
below.																		
SIGNED						DATE_		SIGNED										
							15. IF PATIENT HAS HAD SAME OR SIMPLAR ILLNESS. GIVE FIRST DATE MM   DD   YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION						
MM   DD   YY   INJURY (Accident) OR   PREGNANCY(LMP)						GIVE FIF	RST DATE	MM I DU	FROM DD YY TO YY									
7. NAME OF REFERR				OURCE	178	a. I.D. NU	MBER OF	REFERRING	PHYSICIAN					ED TO	CURRE	NT SERVICES	$\neg$	
										FROM	M   DD	YY		то		00   77		
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? \$ CHARGES						<u> </u>	ヿ	
										□YE	s $\square$	NO I				1	- }	
21. DIAGNOSIS OR NA	TUPE OF	I I NESS OF	IN II IO	Y (851 A	TE ITEMS	12308	4 TO ITE	A 24E RY I INF	<u> </u>	22. MEDICA			N			1	$\dashv$	
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<u>1 382.9</u>						3. L		23. PRIOR AUTHORIZATION NUMBER							$\dashv$			
										23. PRIOR	AU I HUNIZ	A I TON I	NUMBER	n				
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24. A			В	C	22225	050 65	D D	O CURRUES	E	<u> </u>		G DAVS	EPSOT	<del>                                     </del>	J	K	-	
DATE(S) OF			Place	اتتخا	(Expl	ain Linux	ual Circums	R SUPPLIES stances)	DIAGNOSIS	\$ CHA	RGES	OR	Family		COB	RESERVED FOR LOCAL USE		
MM DD YY	MM	DD YY	Service	Service	CPT/HCP	CS 1	MODIFIE	H &		<b>a</b>	Ţ	UNITS	Plan	<del>                                     </del>	<del>                                     </del>		$\dashv$	
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25. FEDERAL TAX I.D.	NUMBER	SSN	EIN	26. F	PATIENTS	ACCOUN	IT NO.	27. ACCE	PT ASSIGNMENT? vt. claims, see back	28. TOTAL	CHARGE		29. AMC	OUNT P	AXO	30. BALANCE DUE		
					1234	5		YES		s	65.	.00	\$		!	\$ 65,0	10	
31. SIGNATURE OF PH	HYSICIAN	OR SUPPLIF	ER.	32.1			S OF FAC		SERVICES WERE	33. PHYSI			'S BILLII	NG NAA	ME, ADD	RESS, ZIP CODE		
INCLUDING DEGR	EES OR C	REDENTIAL	.S		RENDEREC					& PHO	ME #							
(I certify that the statements on the reverse apply to this bill and are made a part thereof.)											C.S. Community Health Smart Road							
uppry to time on all d		1	مام															
Signature on Tile 3/20/01											Smithfield, NC 55555							
SIGNATOR	- (	DATE	;					PIN# 7923441 GRP# 343000Ā										